Department of HUMAN SERVICES

Health Home Learning Collaborative

Incorporating Specialist's plan of care with the Health Home Plan of care

July 2021

This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid Enterprise

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AGENDA

1. Introductions
2. Incorporating Specialist's plan of care with the Health Home Plan of care……Bill Ocker
3. Q&A ……All
4. Open Discussion……All

(Open discussion on current issues or barriers, potentially leading to future monthly topics)

Coming up (Subject to Change):

- *August 16, 2021: Person-Centered Planning Philosophy*
- *September 29, 2021: Fall Face-to-Face Learning Collaborative*
- *November, 15, 2021: Grievance, Appeals, Member Rights, and Guardianship*

Logistics

- Mute your line
- Do not put us on hold
- We expect attendance and engagement
- Type questions in the chat as you think of them, we will address them at the end.

Objectives

- MCO tools to support the Health Home
- SPA Requirements
- Referrals
- Care Planning

Consultations

Referrals

Transfers of Care

Consultations

- **According to the American Academy of Family Physicians (AAFP)**

A consultation is a request from one physician to another for an advisory opinion. The consultant performs the requested service and makes written recommendations regarding diagnosis and treatment to the requesting physician. The requesting physician utilizes the consultant's opinion combined with his own professional judgment and other considerations (e.g. patient preferences, other consultations, family concerns, and comorbidities) to provide treatment for the patient.

Referrals

According to the American Academy of Family Physicians (AAFP)

A referral is a request from one physician to another to assume responsibility for management of one or more of a patient's specified problems. This may be for a specified period of time, until the problem(s) is resolved, or on an ongoing basis. This represents a temporary or partial transfer of care to another physician for a particular condition. It is the responsibility of the physician accepting the referral to maintain appropriate and timely communication with the referring physician and to seek approval from the referring physician for treating or referring the patient for any other condition that is not part of the original referral.

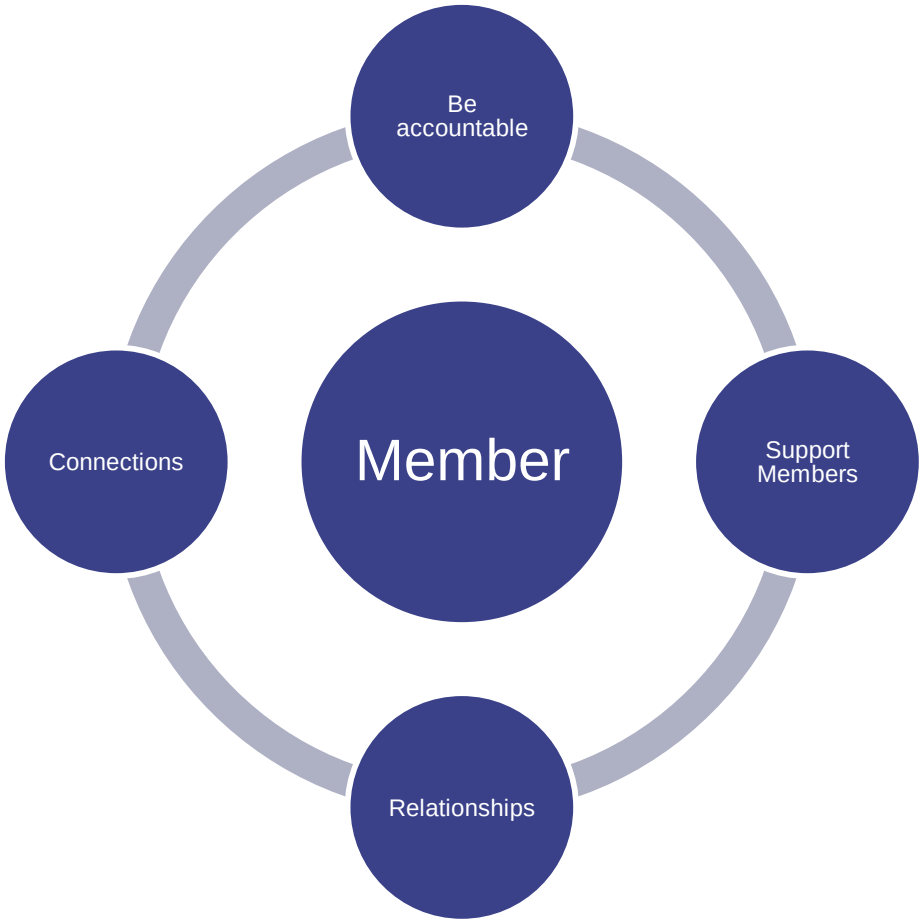
Transfers of Care

A transfer of care occurs when one physician turns over responsibility for the comprehensive care of a patient to another physician. The transfer may be initiated by either the patient or by the patient's physician, and it may be either permanent or for a limited period of time until the patient's condition improves or resolves, or based on the patient wishes. When initiated by the patient's physician, the transferring physician should explicitly inform the patient of the transfer, and assist the patient with timely transfer of care consistent with local practice.

Challenges

What can be done

Primary care practices must be the hub for all the services their members receive. This means:



Why is this important

Coordination of Specialty Referrals and Physician Satisfaction With Referral Care

Christopher B. Forrest, MD, PhD; Gordon B. Glade, MD; Alison E. Baker, MS; et al

Took a sample of 963 referrals made from pediatricians to a specialist.

Results – "Pediatricians scheduled appointments with specialists for 39.3% and sent patient information to specialists for 50.8% of referrals. The adjusted odds of referral completion were increased 3-fold for those referrals for which the pediatrician scheduled the appointment and communicated with the specialist compared with those for which neither activity occurred. Referring physicians' satisfaction ratings were significantly increased by any type of specialist feedback and were highest for referrals involving specialist feedback by both telephone and letter. Elements of specialists' letters that significantly increased physician ratings of letter quality included presence of patient history, suggestions for future care, follow-up arrangements, and plans for co-managing care; only the inclusion of plans for co-managing patient care was significantly related to the referring physicians' overall satisfaction."

Example

- Member has diabetes.
  - Decide what action needs done if any.
    - **Consultations**

      Referrals

      Transfers of Care

Health Home Role

- **Monthly Contact with Member, inquire about**
  - Blood sugars ranges over the past week or two
    - Have any been high or low
  - If they have had any diabetic pain in feet, tingling in feet/hands, blurry visions, etc.
  - When they last saw health professional for diabetic check up
  - Any changes to insulin, diet, exercise
  - Review diabetic crisis/safety plan to see if any updates need made

- **Person Center Service Plan**
  - Risk - identify diabetes as a risk and specifically identify how that looks for the member
  - Crisis and Safety Plan - are developed with the healthcare professionals and members on how to manage high/low sugars, when to call the health professional when sugars are not in range, when to go to emergency room, etc.
  - Goals/Supports – specific to member on how to support the member to learn and manage diabetes with minimal support. Could consist of goals such as: learn about diabetes, medications how to take and when, identifying symptoms of high vs. low sugars, improving eating habits, increasing daily exercise, accessing community resources/professionals to learn more, etc.

Health Home Role Continued

- **Contact health professional(s)**
  - Reach out to on a monthly, quarterly, bi-annually (depending on members need) to stay informed on plans they are working with the member on to support that goal/service and identify them in the plan.
  - Assist with keeping provider informed on what you are seeing and/or member is reporting to you.
  - Make referrals to health professionals, as needed to help member
  - Follow up, if member goes to emergency room or is hospitalized due to diabetes complications

- **Monitor for care gaps**
  - Encourage/support member with remaining compliant
  - Explain benefits this has on their overall health by closing those gaps.

Health Home Role Continued

- **Core Services**
  - The Health Home can provide any time they are addressing member diabetic issues (could be or multiple ones during one visit)
    - Chronic Care Management
    - Care Coordination
    - Health Promotion
    - Comprehensive Transitional Care
    - Individual & Family Support Services
    - Referral to Community and Social Support Services

Chronic Care Management

- Outreach to member
- Assessment
- Care planning
- Monitoring
- Continuity of Care Documents
- Screening

Care Coordination

- Medication Adherence
- Appointments
- Referrals
- Education
- Support

Health Promotion

- Interventions
- Health Management
- Outcomes
- Prevention
- Lifestyle

Comprehensive Transitional Care

- Nursing Facility
- Hospital
- Rehab Facility
- Community Based Group Home
- Family
- Self Care
- Health Home

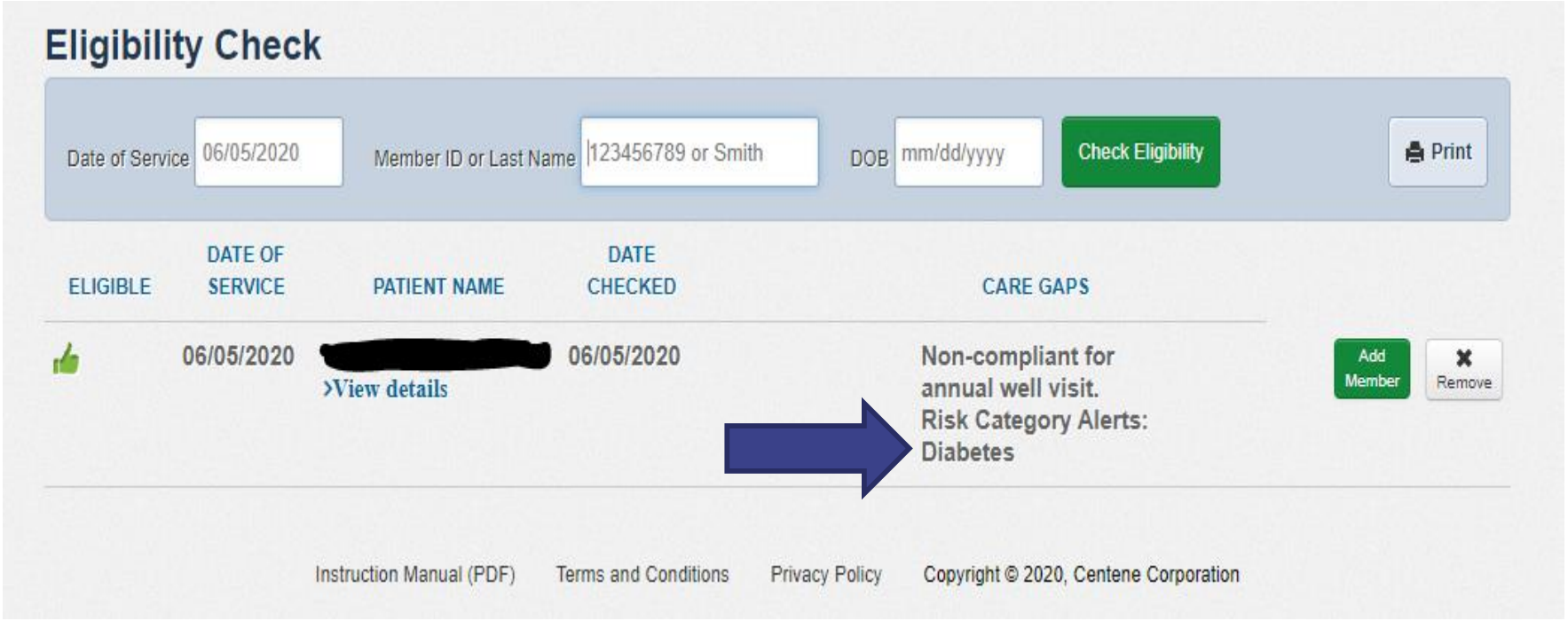
Individual & Family Support Services

- Communication
- Advocating
- Education
- Assessment

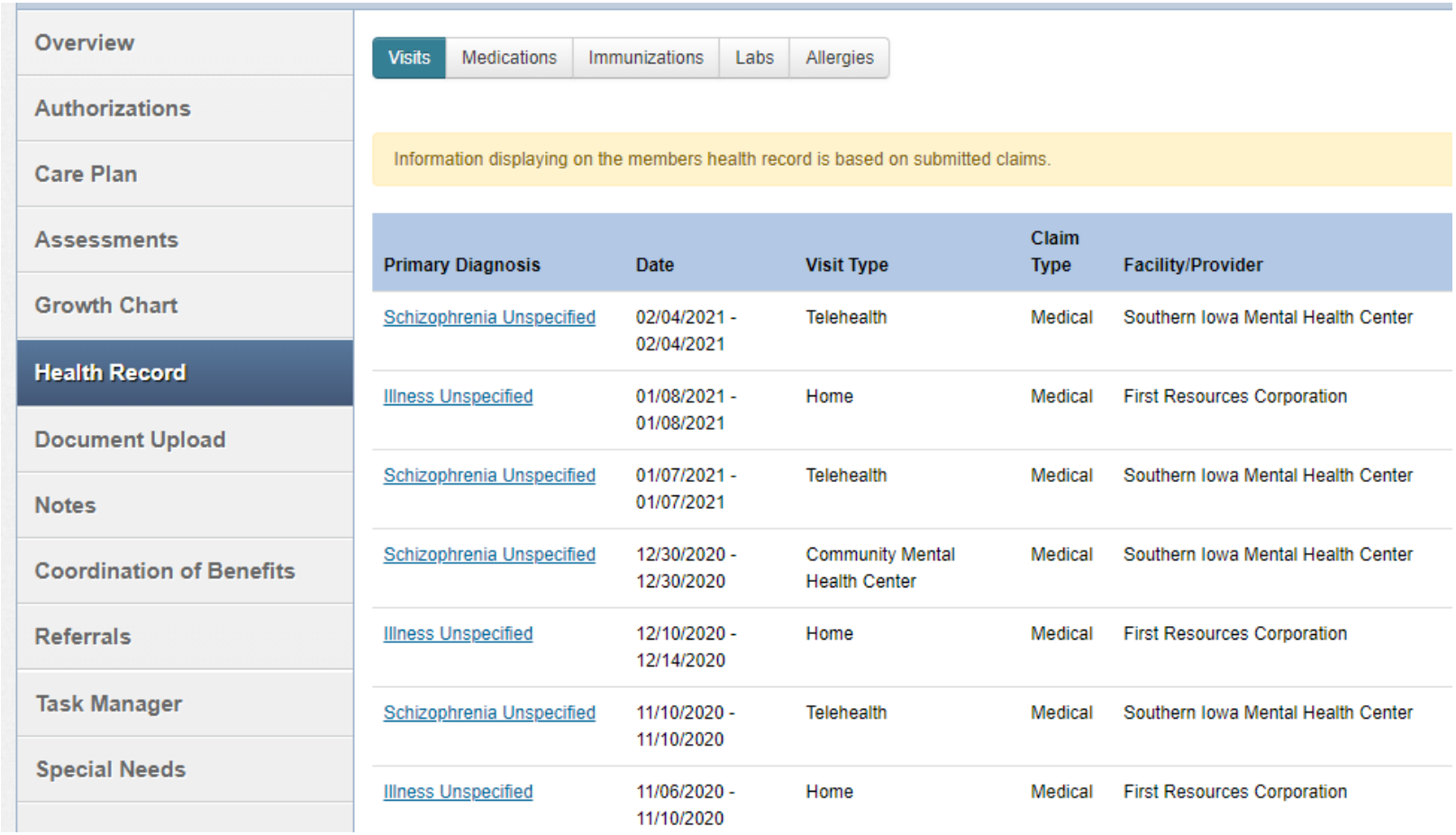
Referral to Community and Social Support Services

- Referrals
- Coordination
- Education

Iowa Total Care Portal



Iowa Total Care Portal



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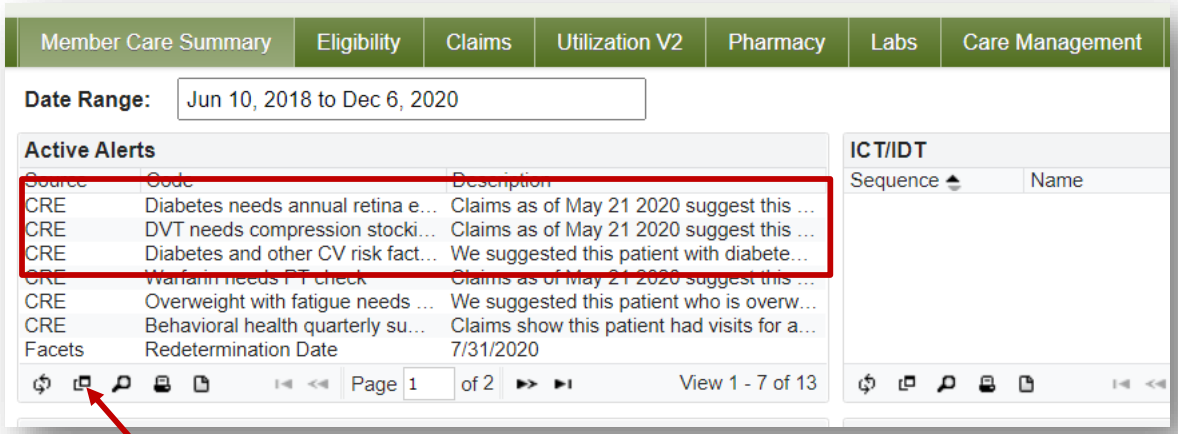
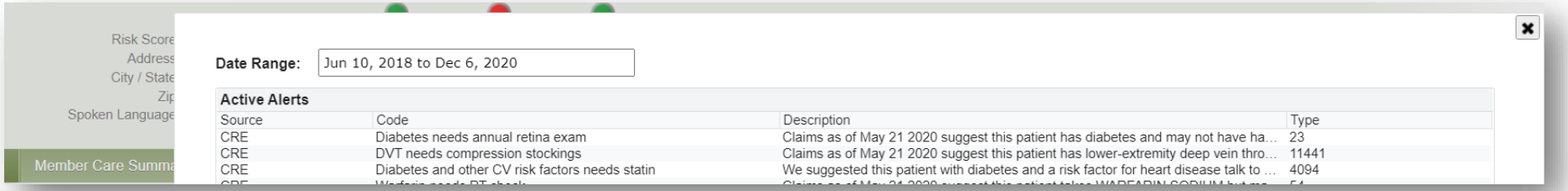
Patient 360- Alerts





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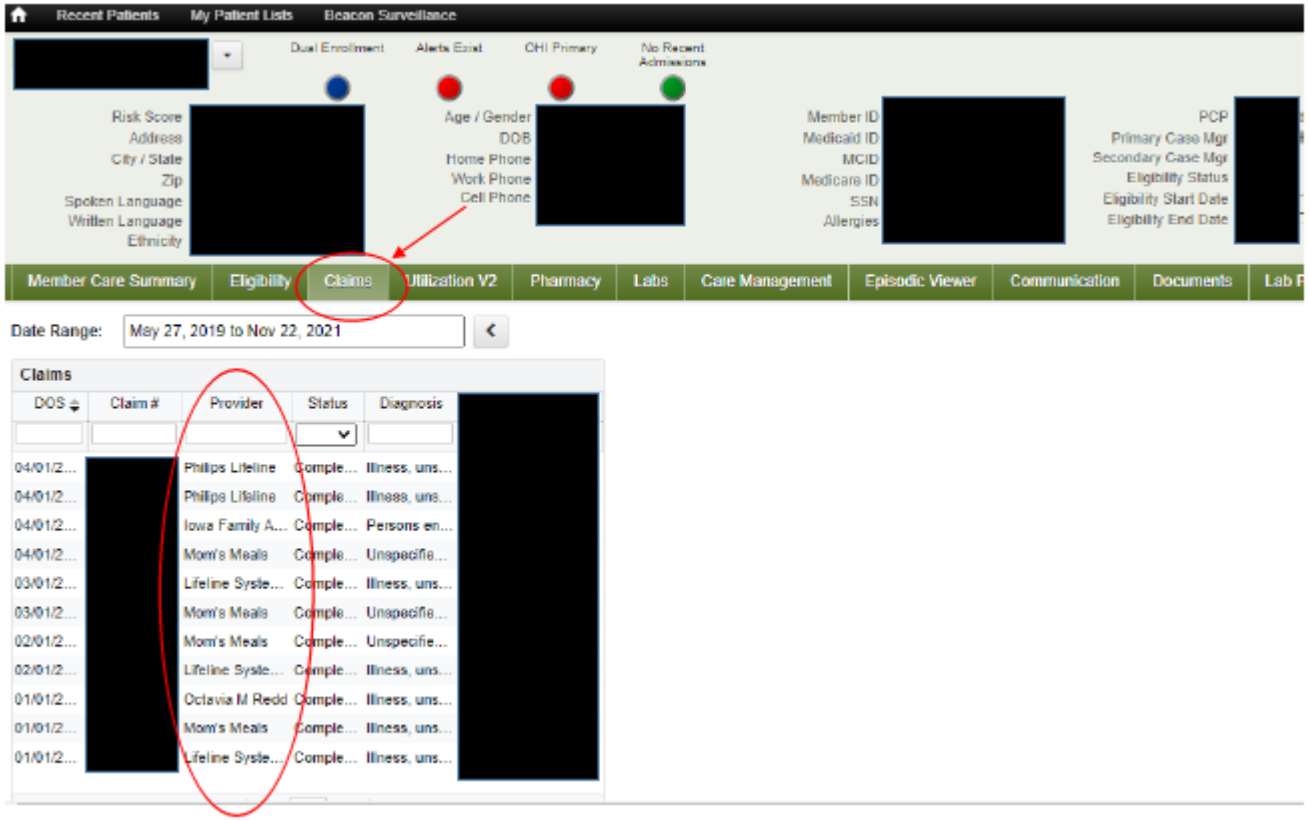
Recent Patients
My Patient Lists
Beacon Surveillance
Dual Enrollment
Alerts Exist
OHI Primary
No Recent Admissions
Risk Score
Address
City / State
Zip
Spoken Language
Written Language
Ethnicity
Age / Gender
DOB
Home Phone
Work Phone
Cell Phone
Member ID
Medicaid ID
MCID
Medicare ID
SSN
Allergies
PCP
Primary Case Mgr
Secondary Case Mgr
Eligibility Status
Eligibility Start Date
Eligibility End Date
Member Care Summary
Eligibility
Claims
Utilization V2
Pharmacy
Labs
Care Management
Episodic Viewer
Communication
Documents
Date Range:
May 27, 2019 to Nov 22, 2021
Claims
DOS
Claim #
Provider
Status
Diagnosis
Philips Lifeline
Iowa Family A...
Mom's Meals
Lifeline Syste...
Octavia M Redd
Illness, uns...
Persons en...
Unspecifie...

Questions?

Open Discussion

Thank you!